



CHAPTER 523 - COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TARGETED CASE MANAGEMENT SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
New Chapter	Entire Chapter	XXXX	January 1, 2013



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CHAPTER 523—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TARGETED CASE MANAGEMENT SERVICE

INTRODUCTION

The relationship of the targeted case manager with a Medicaid member and his or her family should be one of a partnership. As such, members, parents, and families are not merely spectators of case management recommendations, but active participants in care planning throughout the case management process. This is a necessary perspective in order for the member's needs and/or preferences to be considered and addressed individually and within the environment in which the person resides.

Accordingly, organized strategies that empower members, parents, and families to assume and carry out their responsibilities must be included in this mutual planning process. It is very important that a targeted case manager is aware of and sensitive to the values, attitudes, and beliefs that are unique to each family. Values concerning approaches and styles of parenting and/or family life vary according to culture. The effectiveness of Targeted Case Management (TCM) is positively impacted by a demonstrated respect for cultural variations among families. Thus, it is critical that case managers be able to identify and understand cultural beliefs, values, attitudes, and morals by which beneficiaries and their families operate.

TCM effectiveness is further enhanced when integrated with other services and resources identified through a systems perspective, considering all active participants in the individual's life (including the individual's parents, family, and significant others and any involved service providers). Interagency collaboration is crucial to ensuring that a member's needs are adequately met without duplication of services. Thus, it is important for a system to exist within each agency to ensure that targeted case managers are communicating with other professionals and involved parties, coordinating care and services and meeting the specific needs of each individual and, as appropriate, the needs of families.

TCM is the coordination of services to ensure that eligible Medicaid members have access to a full array of needed services including the appropriate medical, educational, or other services. TCM is responsible for identifying individual problems, needs, strengths, and resources; coordinating services necessary to meet those needs; and monitoring the provision of necessary and appropriate services. This process is intended to assist beneficiaries and as appropriate, their families, in accessing services which are supportive, effective and cost efficient. TCM activities ensure that the changing needs of the Medicaid beneficiary are addressed on an ongoing basis and that appropriate choices are provided from the widest array of options for meeting those needs.



This chapter sets forth the Bureau for Medical Services' requirements for payment of Targeted Case Management Services for persons with mental illness, developmental disabilities, substance-related disorders, and/or victims of domestic violence; rendered by qualified providers to eligible West Virginia Medicaid members.

523.0 DEFINITIONS

Direct Service – a service that is designed to support the individual in his or her community-based setting. A direct service is not designed to change behavior or emotional functioning.

Designated Legal Representative (DLR) – Parent of a minor child, conservator, legal guardian (full or limited), health care surrogate, medical power of attorney, power of attorney, representative payee, or other individual authorized to make certain decisions on behalf of a consumer and operating within the scope of his/her authority.

Credentialing – an individual approved to provide Targeted Case Management Services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners. A provider agency with few clinical staff may designate a credentialing officer.

Internal Curriculum - The training protocol developed and approved by the agency for staff providing Targeted Case Management services.

Service Plan - A written description of the behavioral health services and/or supports that the consumer is to receive. A Service Plan may be otherwise named a "Plan of Service," "Treatment Plan" or other appropriate title.

523.1 TARGETED CASE MANAGEMENT SERVICE

Targeted Case Management Services are federally defined as "those services which assist Medicaid eligible recipients in the target group to gain access to needed medical, behavioral health, social, educational and other services." **Targeted Case Management is not a direct service.**

523.1.1 Child Medical Necessity Standards

(Must meet one of the two categories below):

- 1. Documentation indicates that a child member is eligible for TCM because:**
 - a. The child is between the ages of 3 through 17, and
 - b. The child demonstrates a serious and persistent emotional, behavioral,



developmental and/or substance abuse or dependence disturbance as exemplified by a valid and documented Axis I diagnosis and/or diagnosis of developmental disability as described in the language of the current Diagnostic and Statistical Manual of the American Psychiatric Association; and

- c. The Designated Legal Representative or older child member is documented to be unable to access/provide the service proposed without training or support; and
- d. By virtue of age and effects of the emotional and/or developmental impairments, the child is unable to perform age-appropriate activities of daily living (ADL) without assistance and/or prompting.

OR

2. Documentation indicates that the Child is eligible due to actual or pending removal from placement and:

- a. The child is between the ages of 3 and 17 inclusively and/or is in the custody of the DHHR and;
- b. The child is removed or is pending removal from placement due to allegations of abuse and neglect; and
- c. The appointed foster care entity is not able or qualified to perform the case management task in question.

523.2 Exclusions (Child): The child does not qualify for TCM if:

- 1. The child is currently eligible for case management services through the West Virginia Birth to Three Program, or is in a residential treatment facility, or is in a Psychiatric Residential Treatment Facility (PRTF), or Long-Term Care, or is receiving acute psychiatric care, and/or is enrolled through the I/DD Waiver program, or is residing in an ICF/MR. provided that the community-based provider may supply discharge planning services through Targeted Case Management for eligible children 10 days prior to discharge from acute psychiatric care and 30 days prior to discharge from a long-term care program.
- 2. The child is receiving TCM services from another entity including a county school system.

523.3 Adult Medical Necessity Standards (3 categories)

1. Documentation indicates that an adult member is eligible for TCM because:

- a. The adult is age 18 or older;



- b. The adult demonstrates a serious and persistent emotional, behavioral, developmental and/or substance abuse or dependence disturbance as exemplified by a valid and documented Axis I diagnosis and/or diagnosis of developmental disability as described in the language of the current Diagnostic and Statistical Manual of the American Psychiatric Association;
- c. By virtue of age and effects of the emotional and/or developmental impairments, the adult is unable to perform age-appropriate activities of daily living (ADL) without assistance and/or prompting; and
- d. The Designated Legal Representative or spouse is documented to be unable to provide the service proposed without training or support.

OR

- 2. **Documentation indicates that the adult is approved for but pending initiation of I/DD Waiver Services.** The adult is determined to be eligible to receive services through the I/DD Community-Based Waiver Program however is not yet receiving services.

OR

- 3. **Documentation indicates that the adult is currently and temporarily residing in a licensed domestic violence shelter.**

523.4 Exclusions: The adult is not eligible for TCM services if:

- 1. The adult is currently receiving services through an acute psychiatric care facility; a state-operated psychiatric facility; or a long-term care facility; is enrolled through the I/DD Waiver program; or is an active recipient of Assertive Community Treatment (ACT); Provided that the community-based provider may supply discharge planning services through Targeted Case Management for eligible individuals 10 days prior to discharge from acute psychiatric care and 30 days prior to discharge from a longer term care program.
- 2. The adult is receiving TCM services from another entity.

In order to demonstrate the linkage between emotional/behavioral/developmental disability and functional impairment, the provider's documentation must reflect one or both of the following:

- 1. Because of inability to process and comprehend information, the individual is unable to properly act upon documents or utilize processes regarding benefit eligibility, medication management, budgeting, or otherwise performing activities required to continue to live in a community based setting;



2. Because of interpersonal problems or psychiatric symptomatology, the individual is unable to cooperate with others in order to achieve goals and obtain services necessary for community living.

523.5 PROVIDER ENROLLMENT REQUIREMENTS

In order to participate in the West Virginia Medicaid Program and receive payment from BMS, each provider of Targeted Case Management Services must meet all enrollment criteria as described in Chapter 300 Provider Participation and:

- Meet and maintain all BMS enrollment, certification, and service provision requirements as described in this manual
- Have a current, valid TCM provider agreement on file
- Be licensed under the laws of the State of West Virginia as a Behavioral Health Agency; unless the provider is a domestic violence center. Based on the 1989 Domestic Violence

Act, an agency (domestic violence center) must be licensed as a domestic violence center under Chapter 48, Article 2C of the West Virginia Code.

523.6 TCM AGENCY ADMINISTRATION REQUIREMENTS

- Targeted Case Management agencies must promote effective operation of the various programs and agencies in a manner consistent with applicable State laws, regulations, and procedures. There must be clear policy guidelines for decision making, program operations, and provision for monitoring the same.
- Targeted Case Management providers must have:
 - Provisions for orientation, continuing education, and on-going communication with all applicable governing boards
 - Policies and procedures to protect the rights of members
 - A comprehensive set of personnel policies and procedures
 - Job descriptions and qualifications, including licensure, for all staff employed either directly or by contract with the provider or with an agency contracting with the provider or program
 - Provisions for ensuring staff or contractors possess the skills, attitudes, and knowledge needed to perform job functions, and provisions for performing regular staff evaluations.
 - Written definitions and procedures for use of all volunteers must be maintained.



- Targeted Case Management providers must exhibit effective inter-agency coordination that demonstrates a working knowledge of other community agencies. This means the provider and its contracting agencies must be aware of the specific program goals of other human service agencies, and maintain current information regarding the types of services offered and limitations on these services. Similarly, providers must ensure that other human service agencies are provided with accurate, up-to-date information regarding the provider's services, service limitations, and priorities within those services.

523.7 Criminal and Investigation Background Checks (CIB)

A CIB must be initially conducted by the West Virginia State Police for all staff rendering TCM. Prior to providing any TCM, prospective employees must have a CIB conducted by the West Virginia State Police. If a CIB request has been sent to the West Virginia State Police, TCM providers may do a preliminary check utilizing on-line internet companies and use these results until results from the West Virginia State Police are received. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed if ever convicted of:

- 1) Abduction
- 2) Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
- 3) Any type of felony battery
- 4) Child/adult abuse or neglect
- 5) Crimes which involve the exploitation of a child or an incapacitated adult, including financial exploitation
- 6) Felony arson
- 7) Felony or misdemeanor crime against a child or incapacitated adult which causes harm
- 8) Felony drug related offenses within the last 10 years
- 9) Felony DUI within the last 10 years
- 10) Hate crimes
- 11) Kidnapping
- 12) Murder/ homicide
- 13) Neglect or abuse by a caregiver
- 14) Pornography crimes involving children or incapacitated adults including, but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian depicting a child engaged in sexually explicit conduct
- 15) Purchase or sale of a child
- 16) Sexual offenses including, but not limited to incest, sexual abuse, or indecent exposure



- 17) Healthcare fraud
- 18) Felony forgery

The OIG Medicaid Exclusion List must be checked for every agency employee who provides Medicaid services prior to employment. Persons on the OIG Medicaid Exclusion List cannot provide Medicaid services. This list can be obtained at <http://exclusions.oig.hhs.gov>. An individual who has direct contact with a member cannot continue to be employed if the check discloses previous substantiated child or adult maltreatment by the individual

Results which include a history of Medicaid fraud or abuse or which may place members at risk of personal health and safety must be taken into consideration prior to employment.

If aware of a recent conviction or change in status, appropriate action must be taken and BMS notified about the change.

All payments will be recovered by BMS for services provided by staff:

- 1) Without a valid CIB in their personnel record,
- 2) Convicted of any of the crimes listed above, or
- 3) Excluded by the State or Federal government.

523.8 REQUIREMENTS: STAFF QUALIFICATIONS

Targeted Case Management providers must assure that all staff that provides Targeted Case Management Services to members possesses one of the following qualifications:

- A psychologist with a Masters' or Doctoral degree from an accredited program
- A licensed social worker
- A licensed registered nurse
- A Masters' or Bachelors' degree granted by an accredited college or university in one of the following human services fields:
 - Psychology
 - Criminal Justice
 - Board of Regents with health specialization
 - Recreational Therapy
 - Political Science
 - Nursing
 - Sociology
 - Social Work



- Counseling
 - Teacher Education
 - Behavioral Health
 - Liberal Arts or;
 - Other Degrees approved by the West Virginia Board of Social Work.
- Previous certification on the basis of training and experience by the Bureau of Behavioral Health and Health Facilities.

Providers must maintain documentation of staff qualifications in staff personnel files. Documented evidence includes, but is not limited to: transcripts, licenses, and certificates.

- Targeted Case Management providers must have a review process to ensure that employees providing Targeted Case Management Services possess the minimum qualifications outlined above. The review process must occur upon hiring of new employees and on an annual basis to assure that credentials remain valid.
- Targeted Case Management providers must plan annual staff development and continuing education activities for its employees and contractors that broaden their existing knowledge in the field of mental health, substance abuse, and/or developmental disabilities and related areas.
- Targeted Case Management providers must credential their staff by an internal curriculum specific to Targeted Case Management prior to the staff assuming their Targeted Case Management duties.
- Staff development and continuing education activities must be related to program goals and may include supporting staff by attendance at conferences, university courses, visits to other agencies, use of consultants, and educational presentations within the agency. Documentation of staff continuing education, staff development, and Targeted Case Management Training must be maintained in staff personnel files.

523.9 OTHER ADMINISTRATIVE REQUIREMENTS

- The provider must assure implementation of BMS' policies and procedures pertaining to service planning and documentation and case record review. Case records should be arranged so information can be found quickly and easily. Uniform guidelines for case record organization should be used by staff, so similar information will be found in the same place from case record to case record. Copies of completed release of information forms and consent forms must be filed in the case record.
- Records must contain completed member identifying information. The member's individual plan of service must contain service goals and objectives which are derived from a



comprehensive member assessment, and must stipulate the planned service activities and how they will assist in goal attainment. Termination reports must be filed upon case closure. There should be on-going case record reviews to ensure that records contain current, accurate, and complete information.

523.10 METHOD OF VERIFYING BUREAU FOR MEDICAL SERVICES' REQUIREMENTS

Administrative requirements, as well as provision of services, are subject to review by BMS and/or its contracted agents. Bureau for Medical Services' contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by BMS.

These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in Chapter 800 – Quality and Program Integrity.

523.11 PROCEDURE CODE UNITS, COMPONENTS, LIMITS, AND EXCLUSIONS

PROCEDURE CODE: T1017

SERVICE UNITS: 15 minutes

SERVICE LIMITS: All units must be prior authorized by APS Healthcare, Inc.

PRIOR AUTHORIZATION: Yes

If, between regular service planning sessions, the member requires access to a service not previously mentioned on the case management section of his/her service plan, both the member (or their legal guardian) and their case manager must agree and attach an addendum addressing the needed service to the plan.

For continued eligibility for TCM services, a Medicaid member must meet face to face with an individual providing a Behavioral Health service to them every 30 days. The documentation of such contact must be completed by the targeted case manager or an individual with the minimum of a bachelor's degree such as a physician, nurse practitioner, physician's assistant, therapist, counselor, or case manager. The Bachelor's degree must be in one of the eligible areas described under the section entitled "Staff Qualifications."

The case manager must have at least one face-to-face contact for a valid Targeted Case Management activity with the member every 90 days. Any TCM service may be conducted via Tele-medicine with the exception of the 90 day Face to Face encounter with the Targeted Case Manager.



523.12 COMPONENTS OF TARGETED CASE MANAGEMENT SERVICES

Within Targeted Case Management are a number of activities federally recognized as components of case management. These components are:

- **Assessment:**
The case manager ensures an on-going formal and informal process to collect and interpret information about a member's strengths, needs, resources, and life goals. This process is to be used in the development of an individualized service plan. Assessment is a collaborative process between the member, his/her family, and the case manager.
- **Service Planning:**
The case manager ensures and facilitates the development of a comprehensive, individualized service plan. The service plan records the full range of services, treatment, and/or other support needs necessary to meet the member's goals. The case manager is responsible for regular service planning reviews based on the member's needs at regularly scheduled intervals. (**Note:** When the case manager participates in a treatment team meeting, the services provided are not billable as Targeted Case Management.)
- **Linkage/Referral:**
Case managers ensure linkage to all internal and external services and supports identified in the member's service plan.
- **Advocacy:**
Targeted Case Management advocacy refers to the actions undertaken on behalf of the member in order to ensure continuity of services, system flexibility, integrated services, proper utilization of facilities, and resources, and accessibility to services. This includes assuring that the member's legal and human rights are protected.
- **Crisis Response Planning:**
The case manager must ensure that adequate and appropriate crisis response procedures are available to the member and identified in the individual service plan. The case manager assists the member as necessary in accessing crisis support services and interventions.
- **Service Plan Evaluation:**
The case manager continually evaluates the appropriateness of the member's service plan and makes appropriate modifications, establish new linkages, or engage in other dispositions as necessary, up to and including discharge planning as appropriate.



- **Monitoring and Follow-up:**

The Case Manager ensures appropriate quality, quantity and effectiveness of service in accordance with the Service Plan. The Case Manager may only utilize and bill for this component when one of the above stated components have been utilized and determined to be a valid TCM activity. The amount of time spent to “monitor/follow-up” a TCM service shall not exceed the amount of time spent rendering the valid activity.

Note: These components do not constitute separate services and cannot be billed as separate services, but are identified and defined here to assist case managers in understanding their roles and responsibilities.

523.13 SERVICE LIMITATIONS

General Service limitations governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 300, Provider Participation of the Provider Manual. In addition to the requirements for payment of services described in this chapter, Targeted Case Management Services will not be authorized prior to a member's discharge from an Intermediate Care Facility/Mental Retardation (ICF/MR) or an inpatient psychiatric facility except for those provided within 30 days prior to discharge as part of the discharge process.

523.14 SERVICE EXCLUSIONS

In addition to the exclusions listed in Chapter 100, General Information of the Provider Manual, members who receive case management services under the Home and Community-Based Services Waivers granted under Section 1915(c) of the Social Security Act are excluded from receiving Targeted Case Management reimbursement through this service option.

Payment for Targeted Case Management Services must not duplicate payments made to other entities for case management/service coordination services.

523.15 MEMBER CHOICE OF SINGLE TARGETED CASE MANAGEMENT PROVIDER

Each member or their legal guardian must be provided information, by the provider with whom they are seeking services, about the availability of all Medicaid-enrolled providers rendering Targeted Case Management services.

The member must be given an opportunity to choose only one approved Targeted Case Management provider and must indicate this choice on BMS-approved “Medicaid Targeted Case Management Client Enrollment” form.



A signed copy of the “Medicaid Targeted Case Management Client Enrollment” form must be retained in the member’s record and must serve as an enrollment, disenrollment, or re-enrollment of the member with the provider.

The Bureau for Medical Services reimburses only for Targeted Case Management Services provided by the Medicaid-enrolled provider chosen by the member.

A member may choose a new Targeted Case Management provider at any time. The effective date of the change of providers will be the first day of the month following the change.

523.16 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Targeted Case Management providers must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information and Chapter 300, Provider Participation, of the BMS Provider Manual. In addition to the documentation requirements described in this chapter, the following requirements also apply to payment of Targeted Case Management Services:

A Medicaid-enrolled provider of Targeted Case Management Services must maintain the following information/documentation:

- An individual permanent clinical record for each member receiving Targeted Case Management Services.
- Evidence in each clinical record that the member is shown to be in a targeted population as defined in Section 523.1 or 523.3.
- An individualized service plan detailing the need for Targeted Case Management Services which is updated at 90-day intervals or more frequently if indicated by member need.
- A clinical record that must include documentation specific to services/activities reimbursed as Medicaid Targeted Case Management. This includes a specific note for each individual case management service/activity provided and billed.

Each case note must:

- Be dated and signed by the case manager along with a listing of the case manager’s credentials, e.g. LSW, MA;
- Have relevance to a goal or objective in the individual’s plan of service;



- Include the purpose and content of the activity as well as the outcome achieved;
- Include a description of the type of contact provided (e.g., face-to-face, correspondence, telephone contacts);
- Detail the TCM component of the valid activity provided; (i.e., assessment, service planning, linkage/referral, advocacy, crisis response planning, service plan evaluation and monitoring/follow-up);
- List the location the activity occurred; and
- List the actual time spent providing each activity by itemizing the start - and - stop time.

A Targeted Case Management unit of service consists of a 15-minute period of time. Claims must not be processed for less than a full unit of service. Consequently, in filing claims for Medicaid reimbursement, the amount of time documented in minutes must be totaled and divided by 15. Partial units must be rounded down to arrive at the number of units billed. After arriving at the number of billable units, the last date of service provision must be billed as the date of service. **The billing period cannot overlap calendar months.**

The documentation must demonstrate that only one staff person's time is billed for any specific activity provided to the member.

523.17 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of Targeted Case Management Services will apply pursuant to the following limitations.

523.18 PRIOR AUTHORIZATION PROCEDURES

BMS requires that providers prior authorize all Targeted Case Management Services with BMS's contracted agent. Refer to the BMS website <http://www.dhhr.wv.gov/bms/Pages/default.aspx> regarding information on the BMS Utilization Management Contractor.

General information on prior authorization requirements for Targeted Case Management Services and contact information for submitting a request may be obtained by contacting BMS' contracted agent.

523.19 PRIOR AUTHORIZATION REQUIREMENTS



- Prior authorization requests for Targeted Case Management Services must be submitted within the timelines required by BMS' contracted agent.
- Prior authorization requests must be submitted in a manner specified by BMS' contracted agent.